STATE OF MARYLAND

DHMH

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May 18, 2012

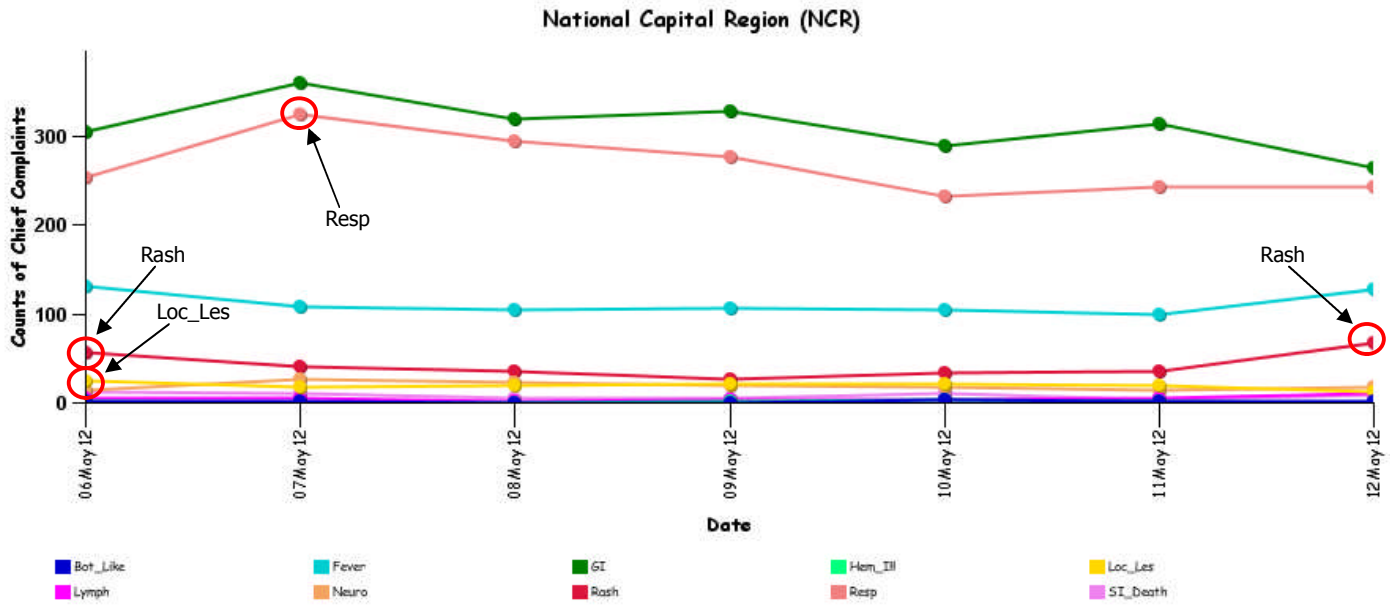
Public Health & Emergency Preparedness Bulletin: # 2012:19
Reporting for the week ending 05/12/12 (MMWR Week #19)

CURRENT HOMELAND SECURITY THREAT LEVELS

National: **No Active Alerts**
Maryland: **Level One (MEMA status)**

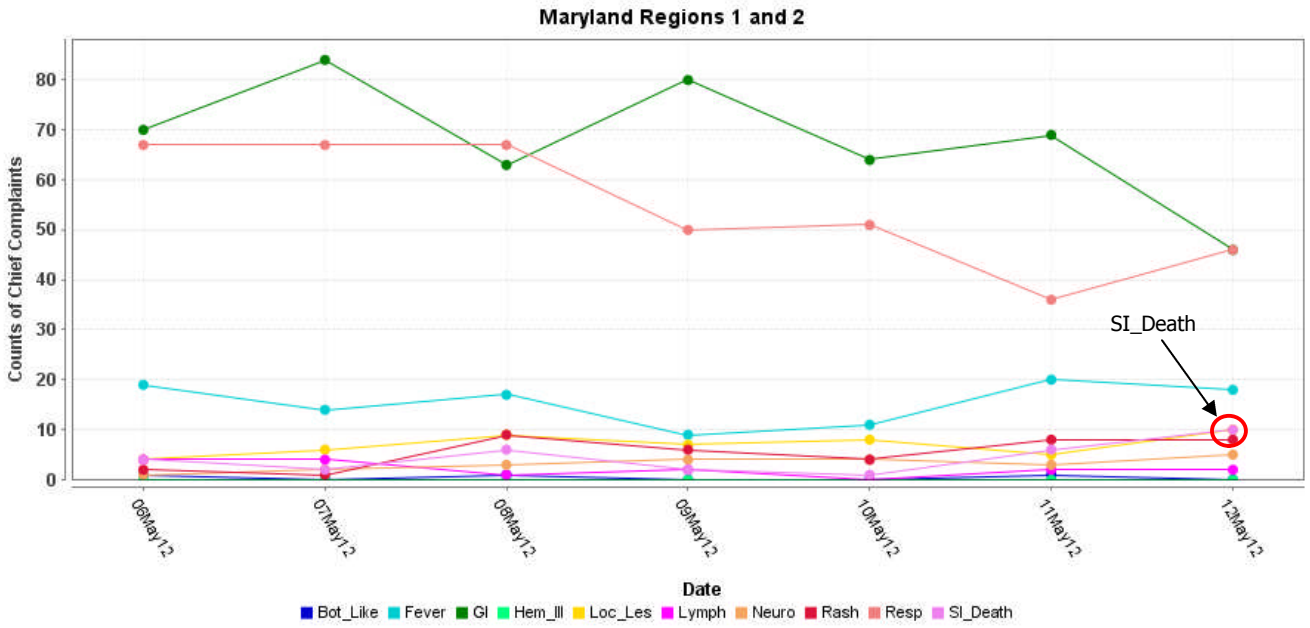
SYNDROMIC SURVEILLANCE REPORTS
ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.

Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

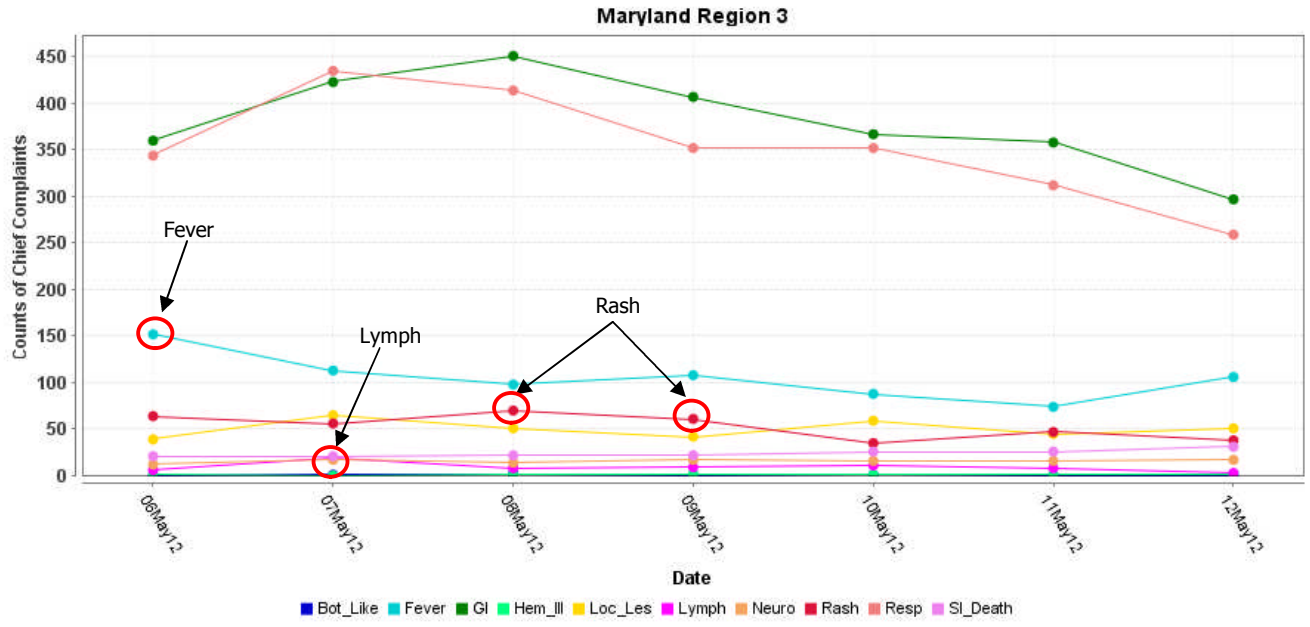


*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

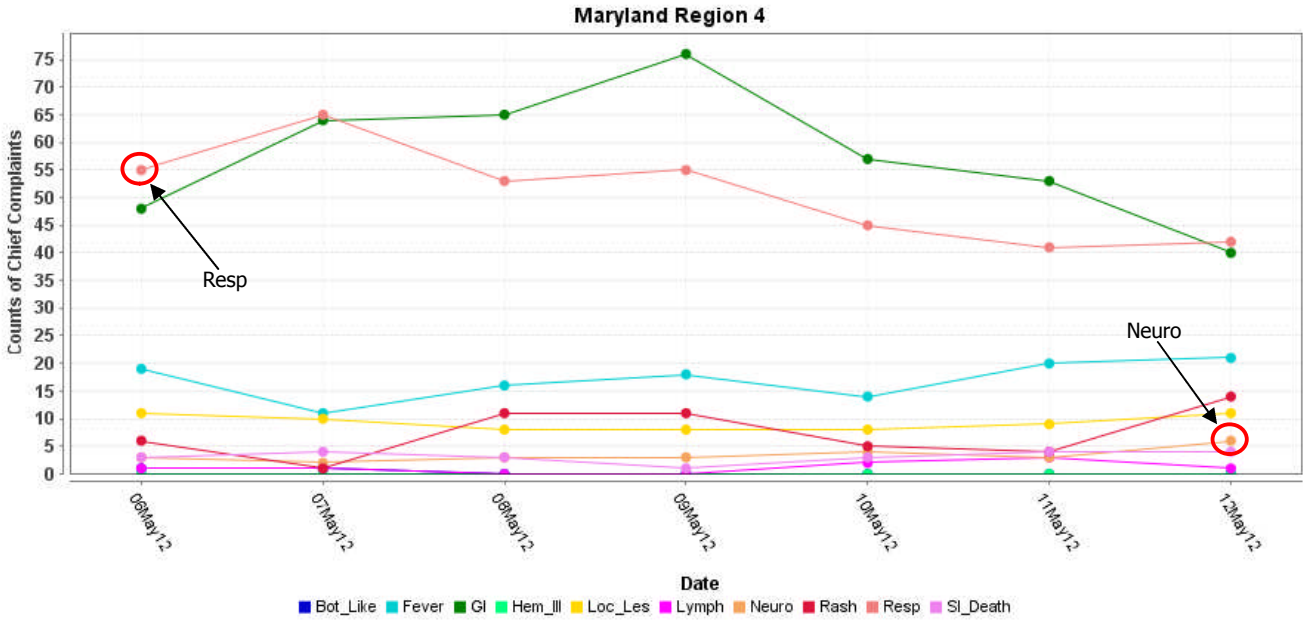
MARYLAND ESSENCE:



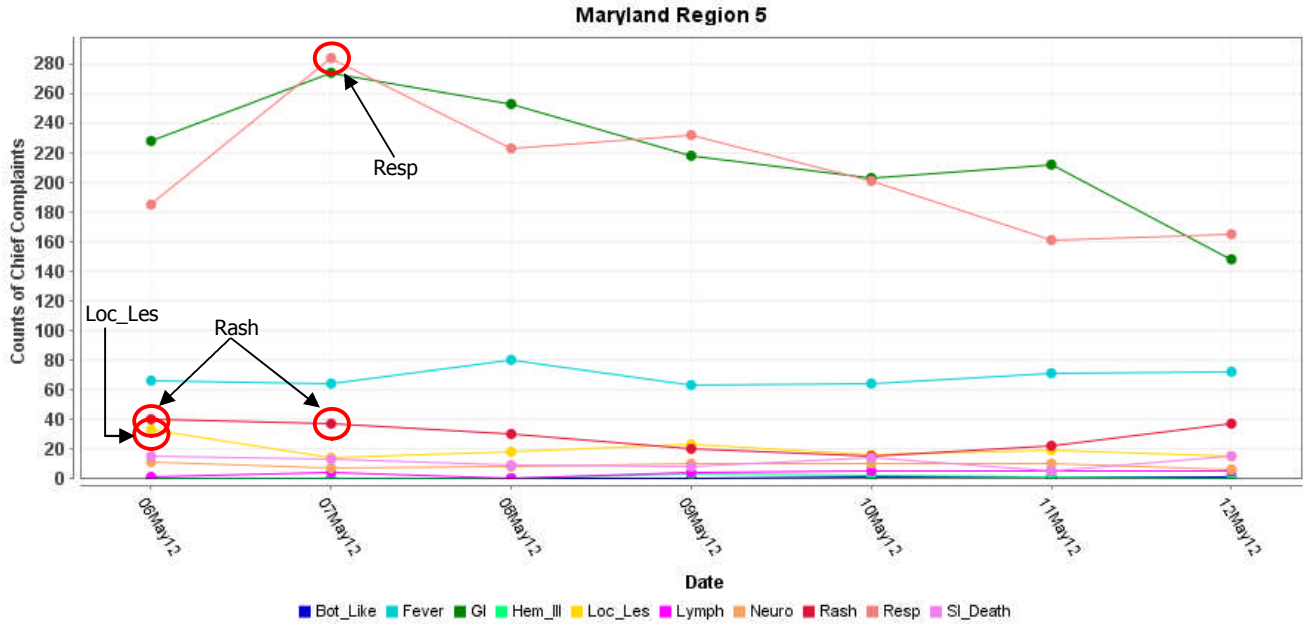
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



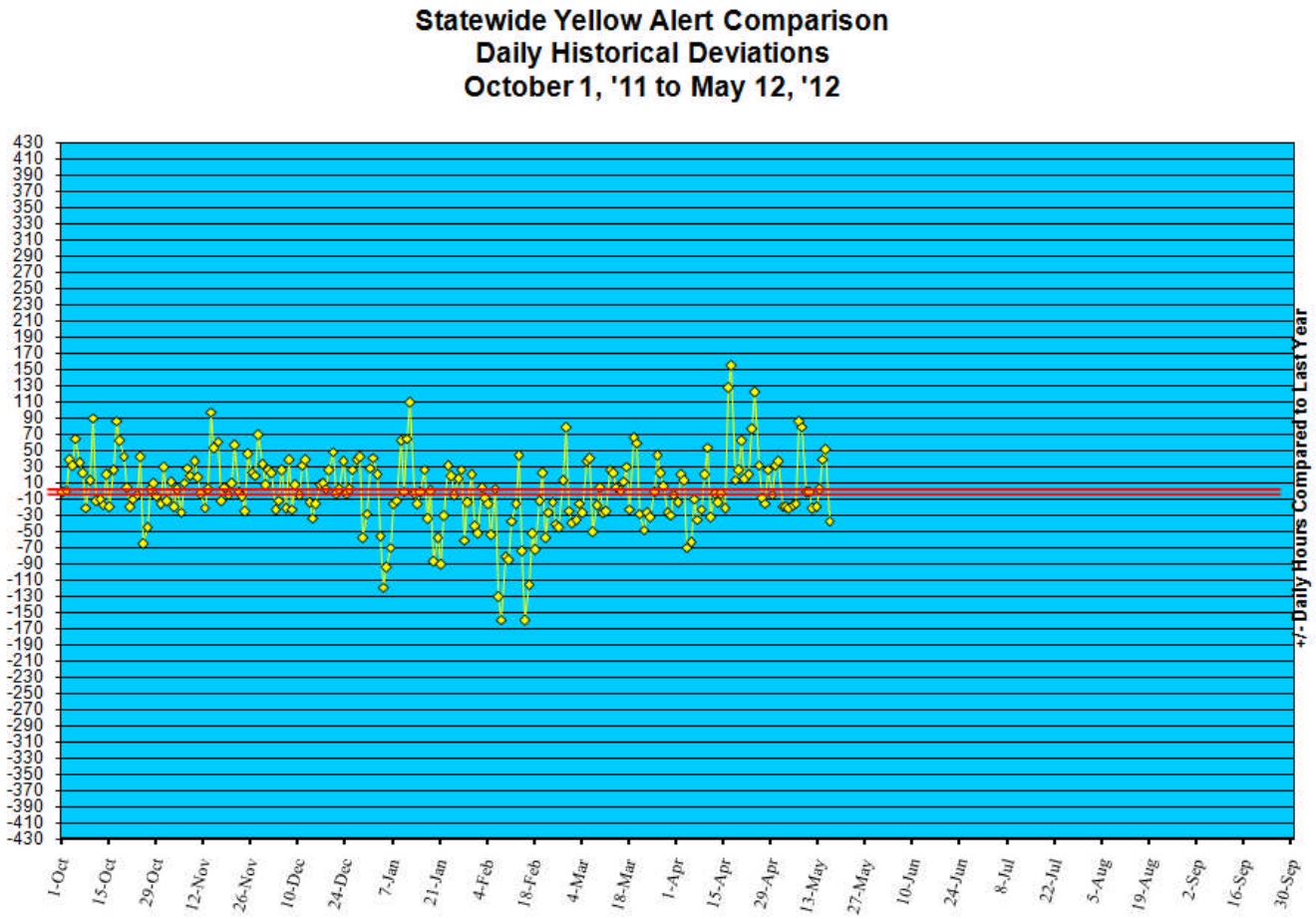
* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE



* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/11.



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in February 2012 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	**Aseptic**	**Meningococcal**
New cases (May 6 – May 12, 2012):	12	0
Prior week (April 29 – May 5, 2012):	8	0
Week#19, 2011 (May 7 – May 13, 2011):	15	0

3 outbreaks were reported to DHMH during MMWR Week 19 (May 6 – May 12, 2012)

2 Gastroenteritis outbreaks
1 outbreak of GASTROENTERITIS in a Nursing Home
1 outbreak of GASTROENTERITIS in a Hotel

1 Foodborne outbreak
1 outbreak of GASTROENTERITIS/FOODBORNE associated with a Restaurant

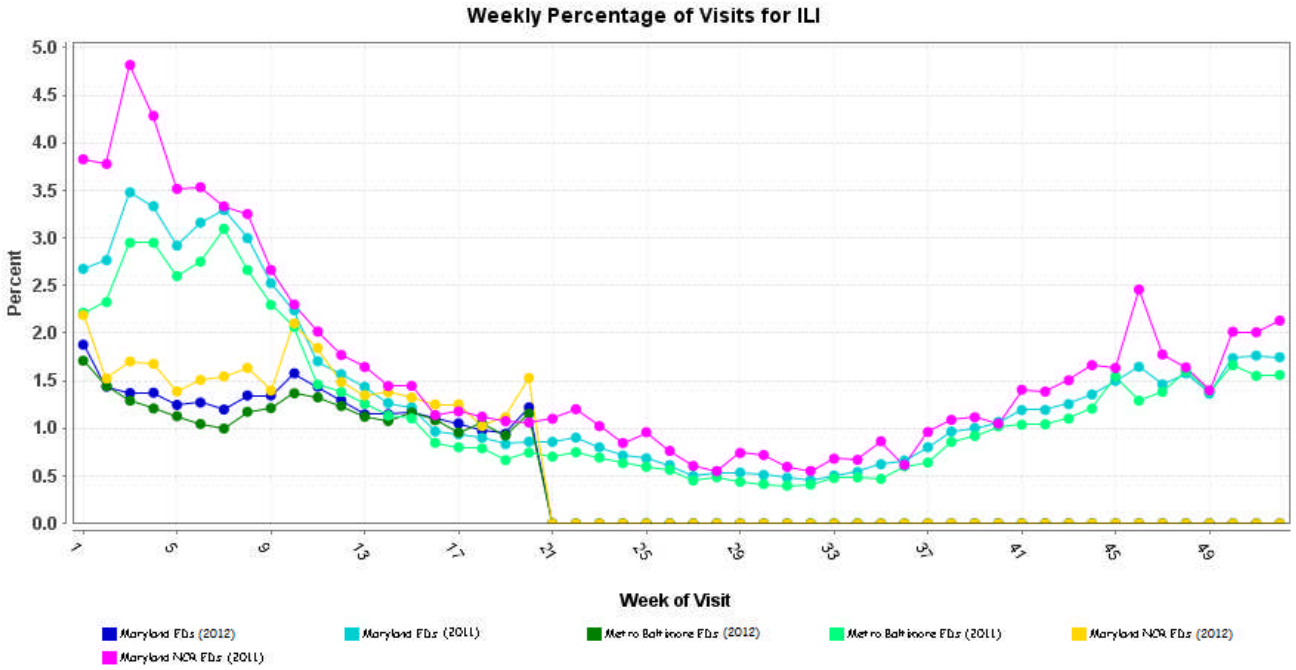
MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting occurs October through May. Seasonal influenza activity for Week 19 was: Sporadic Activity, Minimal Intensity.

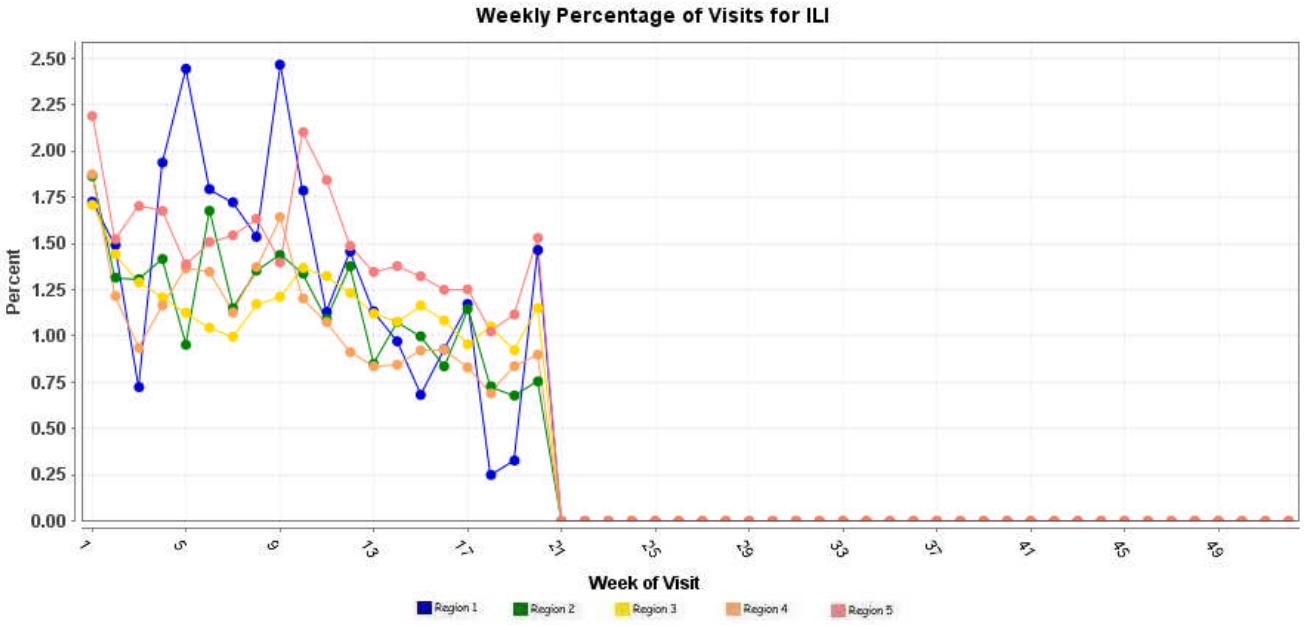
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



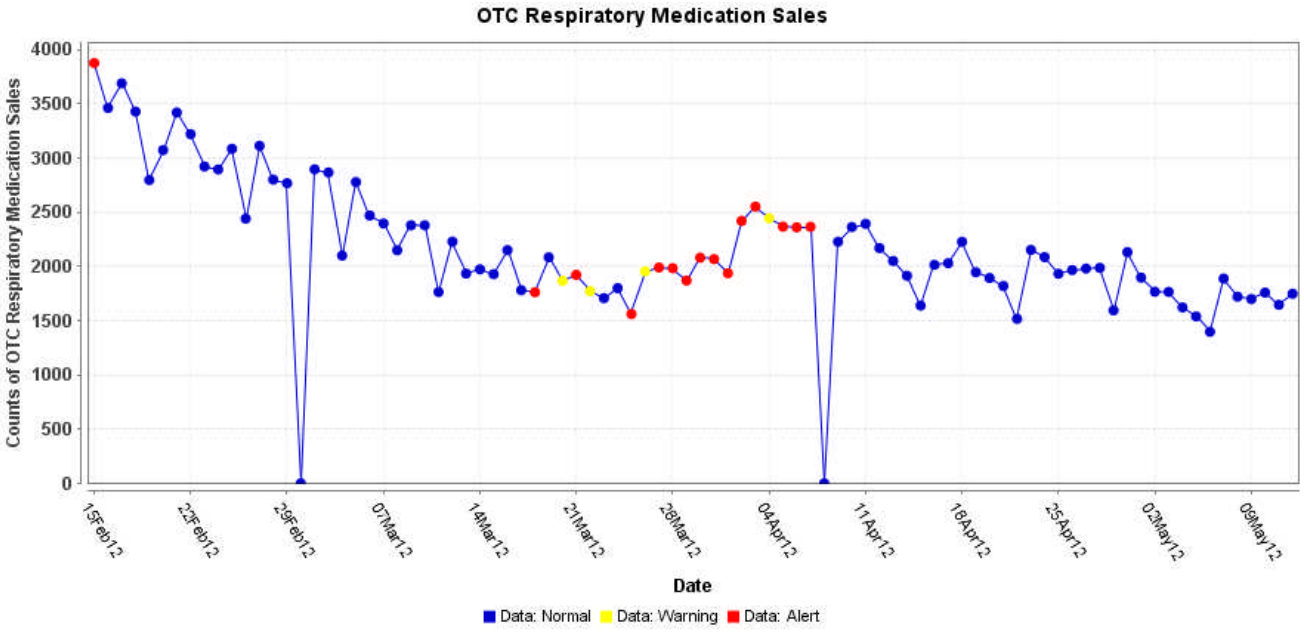
* Includes 2011 and 2012 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2012 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is 3. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

In **Phase 3**, an animal or human-animal influenza reassortant virus has caused sporadic cases or small clusters of disease in people, but has not resulted in human-to-human transmission sufficient to sustain community-level outbreaks. Limited human-to-human transmission may occur under some circumstances, for example, when there is close contact between an infected person and an unprotected caregiver. However, limited transmission under such restricted circumstances does not indicate that the virus has gained the level of transmissibility among humans necessary to cause a pandemic.

As of May 2, 2012, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 603, of which 356 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 59%.

NATIONAL DISEASE REPORTS

NOROVIRUS (LOUISIANA): 12 May 2012, In this outbreak norovirus was suspected on the basis of incubation period, symptoms (vomiting, diarrhea, no fever, etc.) and further confirmed by identification of norovirus in stools of cases. No attempt was made to identify norovirus in oysters. Apparently the process of identifying norovirus in oysters, and food in general is complicated. It was done in the past at a FDA lab on the Gulf coast but it is not done routinely. In such a limited outbreak, the assumption is that the source is an oyster collector or another fisher that relieved himself in the water or dumped the "relief" bucket overboard. An interesting observation in this outbreak is that those who ate broiled oysters also got sick although the odds ratios were much lower than for those who ate raw oysters. Broiled oyster meat was probably not brought to a sufficient temp to inactivate all viruses. Enjoying raw oysters is well worth the small risk of diarrhea. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

E. COLI EHEC (SOUTH CAROLINA): 12 May 2012, South Carolina state health inspectors are investigating an outbreak of *E. coli* linked to a Spartanburg restaurant. Of the 11 suspected or confirmed cases associated with the same restaurant, 2 people were infected to a potentially serious level, said Adam Myrick, spokesman with the SC Department of Health and Environmental Control. DHEC is continuing its "multi-faceted investigation" that includes reviewing restaurant menus, food samples and taking stool samples from those who have related symptoms who have eaten at the restaurant. Myrick wouldn't confirm the restaurant associated with the outbreak. Myrick said the cases were reported during the last week of April 2012 and the 1st week of May 2012. DHEC has since inspected the restaurant and does not have a "reason to believe the public is in danger at this time," Myrick said. "It's early in the investigation and we're piecing together information and talking to people," Myrick said. "We've looked at the facility and found no substantial problems, but again, it's early." The agency issued an alert to local healthcare providers Friday afternoon, 11 May 2012, advising them of the symptoms associated with enterohemorrhagic *E. coli* (EHEC), which include severe stomach cramps, diarrhea (sometimes bloody), vomiting and a mild fever. Myrick said the symptoms commonly last between 5 and 7 days, but children and elderly people are more susceptible to serious complications from the bacteria. According to the CDC, EHEC is the most common outbreak of *E. coli* reported in the USA annually with 265 000 reported illnesses. Of those, about 3600 people are hospitalized and 30 of those cases are fatal. DHEC recommends frequent handwashing, especially for children, since the bacteria can spread, or "shed," for several weeks after symptoms subside. EHEC can be found in undercooked beef, raw milk, unpasteurized apple juice, contaminated water, lettuce, poultry, pork or lamb, according to the CDC. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

CAMPYLOBACTERIOSIS (CALIFORNIA): 11 May 2012, Raw milk, raw skim milk (non-fat), raw cream, and raw butter produced by Organic Pastures Dairy of Fresno County is the subject of a statewide recall and quarantine order announced by California State Veterinarian Dr Annette Whiteford. The quarantine order came following the confirmed detection of _Campylobacter_ bacteria in raw cream. Consumers are strongly urged to dispose of any Organic Pastures products of these types remaining in their refrigerators, and retailers are to pull those products immediately from their shelves. From January through April 2012, the California Department of Public Health (CDPH) reports that at least 10 people with campylobacteriosis were identified throughout California and reported consuming Organic Pastures raw milk prior to illness onset. Their median age is 11.5 years, with 6 under 18. The age range is 9 months to 38 years. They are residents of Fresno, Los Angeles, San Diego, San Luis Obispo, and Santa Clara counties. None of the patients have been hospitalized, and there have been no deaths. According to CDPH, symptoms of campylobacteriosis include diarrhea, abdominal cramps, and fever. Most people with campylobacteriosis recover completely. Illness usually occurs 2 to 5 days after exposure and lasts about a week. The illness is usually mild and some people with campylobacteriosis have no symptoms at all. However, in some persons with compromised immune systems, it can cause a serious, life-threatening infection. A small percentage of people may have joint pain and swelling after infection. In addition, a rare disease called Guillain-Barre syndrome that causes weakness and paralysis can occur several weeks after the initial illness. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

SALMONELLOSIS (NORTH CAROLINA): 10 May 2012, Tests concluded that a food ingredient distributed by a Maryland company is the source of a salmonellosis outbreak that has sickened at least 58 Buncombe County residents. A culture starter for tempeh, a bean product popular in vegetarian cuisine, was found to have the same type of salmonellae that caused a county outbreak beginning as early as February 2012, lab work by the NC Department of Health and Human Services confirmed Thu 10 May 2012. The number of infected county residents increased by 3 from 55 reported Tue 8 May 2012. Other people who visited or otherwise had connections with Buncombe County have also been sickened by the rare type of the bacterium, which has a longer incubation period than more common types. The Rockville, MD, company, Tempeh Online, sold the starter culture to Smiling Hara Tempeh, which made the meat substitute. Federal regulators have been involved, and the Buncombe County Health Department said it is continuing to investigate. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

VIBRIO PARAHAEMOLYTICUS (NORTH CAROLINA): 10 May 2012, Scientists have always warned there would be a price to pay for global warming and 5 people in 2011 paid heavily. State health and fishery officials told shellfishermen and dealers at a meeting Wednesday night, 9 May 2012, that warming ocean waters in the eastern part of Cape Cod Bay have created a more favorable environment for the *Vibrio parahaemolyticus* bacterium, both increasing its population size and lengthening its growing season. The result was that, for the 1st time, the Massachusetts Department of Public Health confirmed that 5 people had fallen ill over the summer and fall of 2011 after eating raw oysters that were contaminated with the bacterium. "This wasn't 5 people getting diarrhea. These people were quite ill, and one came close to death," said Suzanne Condon, associate commissioner at the state

Department of Public Health. The bacteria causes diarrhea, cramping, nausea, vomiting and fever. It can also cause bloodstream infections. Eating raw oysters is the most common way to contract it. After the 1st 2 reported illnesses, which occurred last July 2011 at restaurants in Dennis, the FDA ordered the state DPH and Division of Marine Fisheries to come up with a plan before the summer to protect the public from June to September. The other 3 confirmed cases were from oysters eaten at the Wellfleet OysterFest in the fall of 2011. *Vibrio parahaemolyticus* is a naturally occurring bacterium that likes warmer waters and multiplies rapidly in temperatures above 80 degrees. While Massachusetts average water temperatures are cooler than that, much of the harvesting on Cape Cod Bay in the summer is done on tidal flats where oysters can be exposed to the sun for hours. Plus it can take hours to gather and transport them to the dealer or customers. That gives the bacteria an opportunity to multiply, health officials said. Martin Dowgert, the FDA Northeast Region shellfish specialist, told the audience that scientific studies had determined that refrigerating or icing oysters within the 1st 5 hours after they had either been exposed by the tide or been harvested, with a goal of chilling it enough to lower the oysters' temperature to 50 degrees within 10 hours would stem the exponential growth of the bacteria and keep them at safe levels to be consumed. State officials are holding 2 meetings to ask shellfishermen and dealers how to best protect the public while allowing them to continue harvesting oysters for the raw market in the summer months. "This is not optional," said Mike Hickey, DMF's chief shellfish biologist. What is optional, he added, was their ideas on how to keep oysters cool while working in the hot summer sun. Everyone could name the problems: People couldn't afford refrigerated trucks, dealers weren't open for evening tides, the harvesting process sometimes takes longer than 5 hours. But the bottom line, Hickey said, is finding solutions that could avoid having to close down the fishery in the warm months, or requiring expensive decontamination procedures, or ending the raw oyster market in the summer by only allowing them to be sold for cooking. Much of the rest of the country has such a plan in place because the outbreaks have been more frequent and much more severe. This past week [Week of 7 May 2012], Louisiana had 14 cases of Vibrio sickness, said Michael Moore, director of the DPH Food Protection Program. New York state and the West Coast have had cases where 100 people at a time fell sick. "If 2 cases came across my desk in July, I'd have to do a recall," Moore said, pulling back all raw oysters from dealers and restaurants that came from the area where the contaminated shellfish were harvested. Shellfish, both grown in pens or racks in aquaculture operations, or harvested from the wild, employs thousands and is worth hundreds of millions of dollars, Condon said. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

INTERNATIONAL DISEASE REPORTS

E. COLI 0157 (CANADA): 8 May 2012, Health officials in New Brunswick say they have some leads in their search for the source of an _E. coli_ outbreak that they believe has left people ill in 3 communities. However, a spokeswoman for the Health Department said there is, "still no clear evidence of the source of the outbreak." Jennifer Graham says in an e-mail that 27 cases of bloody diarrhea suspected to be caused by _E. coli_ have been reported since Tue 1 May 2012. The 1st person began showing symptoms on 23 Apr 2012 and as of Friday night, 4 May 2012, 23 cases were reported in Miramichi, 2 in Saint John and 2 in Bathurst. So far, 11 cases have tested positive as *E. coli O157*, a severe strain that can cause serious illness and sometimes lead to kidney failure. Ms. Graham says officials are unsure if the Saint John cases are linked to the Miramichi cases, or if they are from a different source. She said 14 people have been hospitalized, 8 of whom remain in hospital. New Brunswick gets an average of 12 cases of this infection per year. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

CRYPTOSPORIDIOSIS (WALES): 8 May 2012, Public Health Wales and Environmental Health Officers from Cardiff County Council are investigating several cases of diarrheal illness in 6th formers from The Bishop of Llandaff Church in Wales High School, Cardiff. One case has been confirmed with cryptosporidiosis and a further 4 cases are under investigation. The illness has been reported in 6th formers who attended a school trip over the Easter holidays. Symptoms of cryptosporidiosis include watery diarrhea, stomach cramps, vomiting and a slight temperature. Symptoms usually appear within 5 to 7 days following infection. Dr Gwen Lowe, Consultant in Communicable Disease Control for Public Health Wales said: "Following a recent school trip we have been notified of several 6th formers who have been experiencing diarrheal symptoms with one case confirmed as cryptosporidium. "Most people with cryptosporidium will recover without treatment, but in individuals with severely weakened immune systems, a more serious illness may develop. "We are encouraging everyone to observe good hand hygiene precautions to limit the spread of disease. "People are advised to wash their hands with liquid soap and dry them thoroughly after going to the toilet and before preparing or eating food." Anyone who is unwell with gastrointestinal symptoms is advised to contact their GP or NHS Direct on 0845 46 47. People who are unwell with vomiting or diarrhea should not return to work or school for 48 hours after their symptoms have stopped.(Water Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

TRICHINELLOSIS (ARGENTINA): 10 May 2012, An "intra-family" outbreak of trichinosis occurred in the neighboring town of Junin de los Andes, which required the intervention of the authorities from Health Zone IV, who immediately strengthened preventive measures. The Health Area Coordinator of Epidemiology, Fernanda Hada, confirmed this to the newspaper, revealing that the episode took place in a rural zone near to Junin de los Andes and affected 7 people, 4 of whom resided in that locality, and 3 others from elsewhere who shared food and were part of the same family group. It appears as though the boars were killed in the local fields. Hadad warned of the risks of not conducting the analyses for trichinella by the corresponding animal health authorities, which can lead to situations as seen in Junin de los Andes. "Sometimes people think that cooking is enough to eliminate the parasite, but not enough," he said. However, the Health official emphasized that "this is called a domestic [intra-family] outbreak, because it is limited to a specific group", and has nothing to do with the other situation that also occurred in Junin de los Andes years ago, when they discovered that a butcher was selling contaminated pork products. In fact, trichinosis can be contracted not only by eating pork products, but also through other animals that transmit the disease through the consumption of foods made with raw or inadequately cooked meat that is contaminated with trichinella. The disease presents a clinical picture of fever, muscle pains, diarrhea, vomiting, swelling of eyelids and itching. Symptoms can appear up to 45 days after ingestion. Institutions such as Food Science, SENASA or veterinary professionals can analyze a specimen of meat and confirm the presence of the parasite. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

CRIMEAN-CONGO HEMORRHAGIC FEVER (PAKISTAN): 11 May, 2012, NIH, Pakistan, a WHO collaborating center for virology, has sent the following alert to all provincial disease surveillance focal points regarding the peak season for Crimean-Congo hemorrhagic fever (CCHF. There has been an outbreak of 8 cases of CCHF in Pakistan including 3 deaths which have date of onset between 5 Apr to 28 Apr 2012. While the 8 cases have been identified in all 4 provinces and Afghanistan, they are all linked to Balochistan, a known endemic focus of CCHF. 2 cases from DI Khan, Khyber-Pakhtoonkhwa, trade in animals from District Zhob, Balochistan, and wife of one also became ill with confirmed CCHF, a coal miner from District Harnai, Balochistan, a tannary worker from District Quetta, Balochistan, presented at a hospital in Karachi, a butcher from District Pishin, Balochistan, a cattle farmer from Multan, Punjab, also trades in animals from Balochistan, and an Afghan working in Kandahar, Afghanistan, but living in Quetta, Balochistan. All above cases have been confirmed by PCR. All hospital staff need to be reminded to use precautions - at least gloves - when patients present with epistaxis or other hemorrhage. CCHF is up to 50 percent fatal. Oral ribavirin is available to treat with physician supervision. Joint health and veterinary teams are advocating preventive measures in the field. (Viral Hemorrhagic Fevers are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: http://preparedness.dhmh.maryland.gov/

Maryland's Resident Influenza Tracking System: http://dhmh.maryland.gov/flusurvey

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NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail me. If you have information that is pertinent to this notification process, please send it to me to be included in the routine report.

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Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents

Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

Syndrome	Definition	Category A Condition
Botulism-like	ACUTE condition that may represent exposure to botulinum toxin ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy. ACUTE descending motor paralysis (including muscles of respiration) ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.	Botulism
Hemorrhagic Illness	SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria	VHF
Lymphadenitis	ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)	Plague (Bubonic)
Localized Cutaneous Lesion	SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia INCLUDES insect bites EXCLUDES any lesion disseminated over the body or generalized rash EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease	Anthrax (cutaneous) Tularemia
Gastrointestinal	ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea EXCLUDES any chronic conditions such as inflammatory bowel syndrome	Anthrax (gastrointestinal)

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Respiratory	ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media) SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE *acute exacerbation* of chronic illnesses.)	Anthrax (inhalational) Tularemia Plague (pneumonic)
Neurological	ACUTE neurological infection of the central nervous system (CNS) SPECIFIC diagnosis of acute CNS infection such as pneumoccocal meningitis, viral encephailitis ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephailitis NOS, encephalopathy NOS ACUTE non-specific symptoms of CNS infection such as meningismus, delerium EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's	Not applicable
Rash	ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs) SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheaic dermatitis, rosacea EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema	Smallpox
Specific Infection	ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal) INCLUDES septicemia from known bacteria INCLUDES other febrile illnesses such as scarlet fever	Not applicable

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Fever	ACUTE potentially febrile illness of origin not specified INCLUDES fever and septicemia not otherwise specified INCLUDES unspecified viral illness even though unknown if fever is present EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome	Not applicable
Severe Illness or Death potentially due to infectious disease	ACUTE onset of shock or coma from potentially infectious causes EXCLUDES shock from trauma INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths	Not applicable